MDR Tracking Number: M2-03-1457-01
IRO Certificate# 5259

July 29, 2003

REVISED 8/8/03

An independent review of the above-referenced case has been completed by a medical physician [board certified] in physical medicine and rehabilitation. The appropriateness of setting and medical necessity of proposed or rendered services is determined by the application of medical screening criteria published by ___, or by the application of medical screening criteria and protocols formally established by practicing physicians.
All available clinical information, the medical necessity guidelines and the special circumstances of said case was considered in making the determination.

The independent review determination and reasons for the determination, including the clinical basis for the determination, is as follows:

See Attached Physician Determination

___ hereby certifies that the reviewing physician is on Texas Workers' Compensation Commission Approved Doctor List (ADL). Additionally, said physician has certified that no known conflicts of interest exist between him and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for determination prior to referral to ___.

CLINICAL HISTORY
This is a 56 y/o lady who slipped and fell. She sustained injuries to the lumbar spine, left elbow, and tongue. Initial radiographs noted diffuse degenerative changes and no acute findings were reported. This was treated conservatively with a number of modalities, to include physical therapy, injections, medications, and a lumbar corset. She was determined to be at maximum medical improvement and was assigned an impairment rating. The pr from the primary treating physician do not discuss the efficacy of this device. The January 21, 2003 note mentions the device but nothing noting the success of the device in terms of increased function of decreased medications.

REQUESTED SERVICE (S)
Purchase of RS4i Stimulator

DECISION
Endorse the determination already made.

RATIONALE/BASIS FOR DECISION
The proposed device is not broadly accepted as the prevailing standard of care and is not recommended as medically necessary. The problems noted are multiple level degenerative changes, facet arthritis and several disc lesions. This device has no efficacy in the treatment of the diagnosis offered. Moreover, there is no notation in the progress notes of the primary treating physician to support that this device lowered oral analgesics or increased function. Accordingly there is no evidence to support the purchase of this device. Such passive and modalities are indicated in the acute phase of care and their use must be time-limited.

The Philadelphia Panel Physical Therapy Study found little or no supporting evidence to include such modalities in the treatment of chronic pain greater than 6 weeks. Moreover, the efficacy of this type of device in the long-term patient has been studied repeatedly. As noted by Herman (Spine 1994 Mar 1; 19(5): 561) this treatment adds no apparent benefit. Lastly as described by Deyo (NEJM 1990 Jun 7(23): 127-34) TENS is no more effective that placebo. The literature of blinded peer-reviewed studies does not support the efficacy of this device. This device does not improve the situation; there is no identification of a decrease in medication use and the functionality of the claimant was not reported out. The pathology is in the disc; the device requested does not reach the level of the pathology.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) calendar days of your receipt of this decision (20 Tex. Admin. Code 142.5©)

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing, and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) calendar days of your receipt of this decision (28 Tex. Admin. Code 148.3)

This decision is deemed received by you 5 (five) days after it was mailed or the date of fax (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for a hearing and a **copy of this decision** must be sent to:

Chief Clerk of Proceedings/Appeals Clerk
Texas Workers' Compensation Commission
P.O. Box 17787
Austin, Texas 78744

Or fax the request to (512) 804-4011. A copy of this decision must be attached to the request.

The party appealing the decision shall deliver a copy of its written request for a hearing to the opposing party involved in the dispute.

In accordance with Commission Rule 102.4(h), I hereby verify that a copy of this Independent Review Organization (IRO) Decision was sent to the carrier, the requestor and claimant via facsimile or U.S. Postal Service from the office of the IRO on this 30th day of July 2003.